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Quality is Our Bottom Line

Insurance Committee Public Hearing

Tuesday, March 1, 2016

Connecticut Association of Health Plans

Testimony in Opposition to

HB 5230 AA Requiring Health Insurance Coverage for Fertility Preservation for Insureds Diagnosed with Cancer.

The Connecticut Association of Health Plans respectfully requests rejection of HB 5230 AA Requiring Health Insurance Coverage for Fertility Preservation for Insureds Diagnosed with Cancer which we believe qualifies as a new state mandate under the Affordable Care Act (ACA) and, if passed, would thereby require that the State of Connecticut pick-up the associated costs. Please consider the OLR summary as follows for **the same bill considered in 2014 (HB 5245)** which later died in the Appropriations Committee:

> ***The federal Patient Protection and Affordable Care Act (P.L. 111-148) allows a state to require health plans sold through the state's health insurance exchange to offer benefits beyond those included in the required "essential health benefits," provided the state defrays the cost of those additional benefits. The requirement applies to benefit mandates enacted after December 31, 2011. Thus, the state is required to pay the insurance carrier or enrollee to defray the cost of any new benefits mandated after that date.***

Or the fiscal note excerpt from the **same bill considered in 2015 (HB 5320)**:

> ***Lastly, the ACA requires that, the state's health exchange's qualified health plans (QHPs)[5], include a federally defined essential health benefits package (EHB). The federal government is allowing states to choose a benchmark plan[6] to serve as the EHB until 2016 when the federal government is anticipated to revisit the EHB.***
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> ***While states are allowed to mandate benefits in excess of the EHB, the federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage. State mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB for 2014-2015 unless they are already part of the benchmark plan.[7] However, neither the agency nor the mechanism for the state to pay these costs has been established.***

It's also worth noting that none of the mandates under consideration by the Committee would apply to those individuals, including state employees, that are covered by self- insured plans. The burden of this cost would fall only on the fully-insured market who are generally smaller employers.

More and more companies and government entities that can afford to take the risk are moving to self-funded plans which allow them to set their benefit structures more within the scope of their individual group's needs and budget. The ratio of self-insured to fully-insured groups in CT is now nearing 60% to 40%. As the ACA recognized, the system cannot continue to absorb the additional costs of new mandates.

The ACA requires strict adherence to a particular timeline that would be undermined by the various mandates under consideration. Connecticut's Exchange is ***right now*** preparing their standard benefit designs and carriers are ***right now*** preparing their non-standard plan designs. Health carriers must then file the associated rates with the Department of Insurance. If any new mandates or other cost sharing provisions are adopted after the standard benefit design has been finalized and rates have been filed, the Exchange and the carriers will have to ***reopen*** the entire process allowing for adjustments to the AV calculator, re-submittal of all templates and the re-filing of all rates. The sheer volume of mandates and the other insurance provisions under consideration by the Committee add appreciable volatility to the overall process that is not conducive to an efficient, stable and predictable insurance market – all of which would be to the benefit of Connecticut's citizens.

We urge your rejection of HB 5230.